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State/Territory Name: North Dakota

State Plan Amendment (SPA) #: ND-12-006

This file contains the following documents in the order listed:

1) Approval Letter
2) 179
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and CHIP Services

JUN – 4 2012

Maggie D. Anderson, Director
Division of Medical Services
Department of Human Services
600 East Boulevard Avenue
Department 325
Bismarck, ND 58505-0250

Re: North Dakota 12-006

Dear Ms. Anderson:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 12-006. Effective for services on or after January 1, 2012, this amendment updates the State plan to provide for the implementation of the RUG IV classification system; increase rate limits; revise inflationary cost increases; identify accrued salaries as an unallowable cost; revise the allowable education expense limit; provide clarification regarding unallowable costs; and, provides for other minor clarifications.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. We are pleased to inform you that Medicaid State plan amendment TN 12-006 is approved effective January 1, 2012. The HCFA-179 and the amended plan pages are attached.

If you have any questions, please contact Christine Storey at (303) 844-7044.

Sincerely,

Cindy Mann
Director, CMCS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

REVISED 5-25-2012

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL	1. TRANSMITTAL NUMBER: **12-006**	2. STATE **North Dakota**
FOR: HEALTH CARE FINANCING ADMINISTRATION	3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)**	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE **January 1, 2012**	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☒ **NEW STATE PLAN** ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ **AMENDMENT**

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:	7. FEDERAL BUDGET IMPACT:
42 CFR 447.200	a. FFY 2012 $ 2,579,075 b. FFY 2013 $ 811,121
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-D, Pages 62-66 and new Pages 65a & 66a	**Attachment 4.19-D, Pages 62-66, and new pages 65a and 66a**
Attachment 4.19-D, Page31	**Attachment 4.19-D, Page 31**
Attachment 4.19-D, Page 9	**Attachment 4.19-D, Page 9**
Attachment 4.19-D, Page 5	**Attachment 4.19-D, Page 5**
Attachment 4.19-D, Page 22	**Attachment 4.19-D, Page 22**
Attachment 4.19-D, Page 26 & 27	**Attachment 4.19-D, Page 26 & 27**
Attachment 4.19-D, Page 46 & 47	**Attachment 4.19-D, Page 46 & 47**
Attachment 4.19-D, Page 48a	**Attachment 4.19-D, Page 48a**
Attachment 4.19-D, Page 61, and Page 61a (new)	**Attachment 4.19-D, Page 61, and Page 61a (new)**
Attachment 4.19-D, Pages A-1, A-2, A-3, & A-4	**Attachment 4.19-D, Pages A-1, A-2, A-3, & A-4**
Attachment 4.19-D, Pages B-3 & B-4	**Attachment 4.19-D, Pages B-3 & B-4**

10. SUBJECT OF AMENDMENT:

Amends the State Plan to Implement the Resource Utilization Group (RUG) IV classification system, identify the increase for nursing facility services, change the allowable education expense limit, identify salaries accrued at a facility's yearend, but not paid within 75 days of the cost report yearend as an unallowable cost, and additional changes to provide for further detail on reporting requirements.

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: Maggie D. Anderson, Director, Medical Services Division

12. SIGNATURE OF STATE AGENCY OFFICIAL: Maggie D Anderson	16. RETURN TO:
13. TYPED NAME: **Maggie D. Anderson**	**Maggie D. Anderson, Director** **Division of Medical Services** **ND Department of Human Services** **600 East Boulevard Avenue Dept 325** **Bismarck ND 58505-0250**
14. TITLE: **Director, Division of Medical Services**	
15. DATE SUBMITTED: **3-16-2012 REVISED 05-25-2012**	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: JUN - 4 2012
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: JAN - 1 2012	20. SIGNATURE OF REGIONAL OFFICIAL:
21. TYPED NAME: Penny Thompson	22. TITLE: Deputy Director, CMCS
23. REMARKS:	

FORM HCFA-179 (07-92)

Section 2 - Financial Reporting Requirements

1. Records.

   a. The facility shall maintain on the premises the required census records and financial information in a manner sufficient to provide for a proper audit or review. For any cost being claimed on the cost report, sufficient data must be available as of the audit date to fully support the report item.

   b. Where several facilities are associated with a group and their accounting and reports are centrally prepared, added information must be submitted, for those items known to be lacking support at the reporting facility, with the cost report or must be provided to the local facility prior to the audit or review of the facility. Accounting or financial information regarding related organizations must be readily available to substantiate cost. Home office cost reporting and cost allocation must be in conformance with applicable sections in this manual and HCFA-15 paragraphs 2150 and 2153.

   c. Each provider shall maintain, for a period of not less than five years following the date of submission of the cost report to the department, accurate financial and statistical records of the period covered by such cost report in sufficient detail to substantiate the cost data reported. Each provider shall make such records available upon reasonable demand to representatives of the department or to the secretary of health and human services or representatives of the secretary.

   d. Except for motor vehicles used exclusively for resident-related activities, the provider shall maintain a mileage log for all motor vehicles which identifies mileage and purpose of each trip. Vehicle mileage for nonresident-related activities must be documented.

2. Accounting and reporting requirements.

   a. The accrual basis of accounting in accordance with generally accepted accounting principles must be used for cost reporting purposes. A facility may maintain its accounting records on a cash basis during the year, but adjustments must be made to reflect proper accrual accounting procedures at year end and when subsequently reported. Rate setting procedures will prevail if conflicts occur between rate setting procedures and generally accepted accounting principles.

   b. To properly facilitate auditing, the accounting system shall be maintained in a manner that will allow cost accounts to be grouped by cost category and readily traceable to the cost report.

Section 3 - General Cost Principles

1. For rate-setting purposes, a cost must satisfy the following criteria:

   a. The cost is ordinary, necessary, and related to resident care.

   b. The cost is what a prudent and cost conscious business person would pay for the specific good or service in the open market in an arm's length transaction.

   c. The cost is for goods or services actually provided in the facility.

2. The cost effects of transactions which circumvent these rules are not allowable under the principle that the substance of the transaction prevails over form.

3. Reasonable resident-related costs will be determined in accordance with the rate setting procedures set forth in this manual, instructions issued by the department and Health Care Financing Administration Manual 15 (HCFA-15). If conflicts occur between the rate setting manual or instructions issued by the department and HCFA-15, the rate setting manual or instructions issued by the department will prevail.

4. Costs incurred due to management inefficiency, unnecessary care, unnecessary facilities, agreements not to compete, or activities not commonly accepted in the nursing facility industry are not allowable.

b. If total costs of all nonresident-related activities, exclusive of property, administration, chaplain, and utility costs, are less than five percent of total facility costs, exclusive of property, administration, chaplain, and utility costs, administration costs must be allocated to each activity based on the percent gross revenues for the activity is of total gross revenues, except the allocation may not be based on a percentage exceeding two percent for each activity.

c. If the provider can document, to the satisfaction of the department, that none of the nursing facility resources or services are used in connection with the nonresident-related activities, no allocation need be made.

d. The provisions of this subsection do not apply to the activities of hospital and basic care facilities associated with a nursing facility.

e. All costs associated with a vehicle not exclusively used by a facility must be allocated between resident-related and nonresident-related activities based on usage logs.

32. The following taxes:

    a. Federal income and excess profit taxes, including any interest or penalties paid thereon;

    b. State or local income and excess profit taxes;

    c. Taxes in connection with financing, refinancing, refunding, or refunding operation, such as taxes in the issuance of bonds, property transfers, issuance or transfer of stocks, etc., which are generally either amortized over the life of the securities or depreciated over the life of the asset, but not recognized as tax expense;

    d. Taxes such as real estate and sales tax for which exemptions are available to the provider;

    e. Taxes on property not used in the provision of covered services;

    f. Taxes, such as sales taxes, levied against the residents and collected and remitted by the provider.

    g. Self-employment (FICA) taxes applicable to individual proprietors, partners, members of a joint venture;

33. The unvested portion of a facility's accrual for sick or annual leave;

34. The cost, including depreciation, of equipment or items purchased with funds received from a local or state agency, exclusive of any federal funds;

35. Hair care, other than routine hair care, furnished by the facility;

36. The cost of education unless:

    a. The education was provided by an accredited academic or technical educational facility;

    b. The expenses were for materials, books, or tuition;

    c. The facility claims the cost of the education expense, annually, in an amount not to exceed the lesser of the individual's education expense or three-thousand-seven-hundred-fifty dollars; and

d. The amount of education expense claimed for an individual does not exceed fifteen-thousand dollars in the aggregate;

e. The facility has a contract with the individual which stipulates a minimum commitment to work for the facility of one-thousand-six-hundred-sixty-four hours of employment for each year education assistance was provided, as well as a repayment plan if the individual does not fulfill the contract obligations.

37. Vacated

38. Employment benefits associated with salary costs are not includable in a rate set under this plan.

39. Increased lease costs of a provider unless:

a. The lessor incurs increased costs related to the ownership of the facility or a resident-related asset;

b. The increased costs related to the ownership are charged to the lessee; and

c. The increased costs related to the ownership would be allowable had the costs been incurred directly by the lessee;

40. The direct and indirect costs of providing therapy services to nonresidents or Medicare Part B therapy services, including purchase costs related to providing therapy services if the provider does not want therapy income offset under Section 13.1.k.

41. Costs associated with or paid for the acquisition of licensed nursing facility capacity.

42. Goodwill; and

43. Lease costs in excess of the amount allocable to the leased space as reported on the Medicare Cost Report by a lessor who provides services to recipients of benefits under Title XVIII or Title XIX of the Social Security Act.

44. Salaries accrued at a facility's fiscal year end but not paid within seventy-five days of the cost report year end.

Section 15 – Related Organization

1. Costs applicable to services, facilities, and supplies furnished to a provider by a related organization may not exceed the lower of the cost to the related organization or the price of comparable services, facilities, or supplies purchased elsewhere primarily in the local market. Providers shall identify such related organizations and costs in the cost report.

2. A provider may lease a facility from a related organization within the meaning of rate setting principles. In such case, the rent paid to the lessor by the provider is not allowable as cost unless the rent paid is less than the allowable costs of ownership. If rent paid exceeds the allowable costs of ownership, the provider may include the allowable costs of ownership of the facility. These costs are property insurance, depreciation as provided for in Section 18 – Depreciation, Interest on the mortgage as provided for in Section 19 – Interest Expense, and real estate taxes as provided for in Section 20 – Taxes. Other operating expenses of the related organization are not includable by the provider as an allowable cost of ownership.

3. The relationship between a provider and a related organization at the time a transaction between the two parties occurs must govern the treatment of cost regardless of subsequent events that may change the relationship between the parties.

4. In the case of a facility acquired through purchase of shares, interest and depreciation expense are treated in the same manner as if the capital assets of the acquired corporation were acquired as an ongoing operation by the acquiring entity on the day the secretary of state issues a certificate of dissolution of the acquired corporation if organized in North Dakota, or on the day of the acquired corporation is irrevocably dissolved if organized other than in North Dakota, provided the transaction has all of the following characteristics:

    a. The facility was owned and operated by the acquired corporation;

    b. The acquired corporation is irrevocably dissolved, and all of its capital assets become the property of the acquiring entity, within one year after the first day on which any ownership interest in the acquired corporation was acquired by the acquiring entity; and

    c. Neither the acquiring entity nor any related organization of the acquiring entity has had any ownership interest in the acquired corporation, or any ownership interest in any related organization of the acquired corporation, for at least ten years prior to the day the acquiring entity, or a related organization of the acquiring entity, first acquired any ownership interest in the acquired corporation.

5. For purposes of subsection 4, "acquiring entity" means the entity that, upon dissolution of the acquired corporation, owns all the capital assets formerly owned by the acquired corporation.

Section 24 – Adjustment Factors for Direct Care, Other Direct Care and Indirect Care Costs

1. An appropriate economic change index may be used for purposes of adjusting historical costs for direct care, other direct care, and indirect care and for purposes of adjusting limitations of direct care costs, other direct care costs, and indirect care costs, but may not be used to adjust property costs.

2. For the rate year beginning January 1, 2009 the appropriate economic change index is five percent.

3. For the rate year beginning January 1, 2010 the appropriate economic change index is six percent.

4. For the rate year beginning January 1, 2011 the appropriate economic change index is six percent.

5. For the rate year beginning January 1, 2012 the appropriate economic change index is three percent.

Section 25 - Rate Limits and Incentives

1. Limits - All facilities except those nongeriatric facilities for individuals with physical disabilities or units within a nursing facility providing geropsychiatric services described in Section 5 - Exclusions must be used to establish a limit rate for the *Direct Care, Other Direct Care, and Indirect Care cost categories. The base year* is the report year ended June 30, 2006. Base year costs may not be adjusted in any manner or for any reason not provided for in this section.

   a. The limit rate for each of the cost categories will be established as follows:

      (1) Historical costs for the report year ended June 30, 2006, as adjusted must be used to establish rates for all facilities in the Direct Care, Other Direct Care and Indirect Care cost categories. The rates as established must be ranked from low to high for each cost category.

      (2) For the rate year beginning January 1, 2009, the limit rate for each cost category is:

         (a) For the Direct Care cost category, $110.61;
         (b) For the Other Direct Care cost category, $21.29; and
         (c) For the Indirect Care cost category, $52.19.

      (3) For the rate year beginning January 1, 2010, the limit rate for each cost category is:

         (a) For the Direct Care cost category, $115.78;
         (b) For the Other Direct Care cost category, $21.94; and
         (d) For the Indirect Care cost category, $55.42.

      (4) For the rate year beginning January 1, 2011, the limit rate for each cost category is:

         (a) For the Direct Care cost category, $127.50;
         (b) For the Other Direct Care cost category, $23.89; and
         (e) For the Indirect Care cost category, $60.57.

      (5) For the rate year beginning January 1, 2012, the limit rate for each cost category is:

         (a) For the Direct Care cost category, $131.59;
         (b) For the Other Direct Care cost category, $24.67; and
         (c) For the Indirect Care cost category, $62.42.

7. The actual rate for indirect care costs and property costs must be the lesser of the rate established using:

   a. Actual census for the report year; or

   b. Ninety percent of licensed bed capacity available for occupancy as of June thirtieth of the report year.

      (1) Multiplied times three hundred sixty-five; and

      (2) Reduced by the number of affected beds, for each day any bed is not in service during the report year, due to a remodeling, renovation, or construction project.

8. The department may waive or reduce the application of paragraph 7 if the facility demonstrates that occupancy below ninety percent of licensed capacity results from the use of alternative home and community services by individuals who would otherwise be eligible for admission to the facility and:

   a. The facility has reduced licensed capacity; or

   b. The facility's governing board has approved a capacity decreased to occur no later than the end of the rate year which would be affected by subdivision d.

9. The department shall waive the application of paragraph 7 for nongeriatric facilities for individuals with physical disabilities or geropsychiatric facilities or units if occupancy below ninety percent is due to lack of department approved referrals or admissions.

Section 32 – Classifications

1. A facility shall complete a resident assessment for any resident occupying a licensed facility bed, except a respite care, hospice inpatient respite care, or hospice general inpatient care resident.

2. A resident must be classified in one of forty-eight classifications based on the resident assessment. If a resident assessment is not performed in accordance with subsection 3, except for a respite care, hospice inpatient respite care, or hospice general inpatient care resident, the resident must be included in group AAA, not classified, until the next required resident assessment is performed in accordance with subsection 3. For purposes of determining standardized resident days, any resident day classified as group AAA must be assigned the relative weight of one. A resident, except for a respite care hospice inpatient respite care or hospice general inpatient care resident, who has not been classified, must be billed at the group AAA established rate. The case-mix weight for establishing the rate for is .45. Days for respite care, hospice inpatient respite care, or hospice general inpatient care resident who is not classified must be given a weight of one when determining standardized resident days. Therapeutic, hospital, or institutional leave days that are resident days must be given a weight of .45 when determining standardized resident days.

3. Resident assessments must be completed as follows:

    a. The facility shall assess the resident within the first fourteen days after any admission or return from an acute hospital stay. The day of admission or return is counted as day one.

    b. The facility shall assess the resident quarterly after any admission or return from an acute hospital stay. The quarterly assessment period ends on the day of the third subsequent month corresponding to the day of admission or return from an acute hospital stay, except if that month does not have a corresponding date, the quarterly assessment period ends on the first day of the next month. The assessment reference period begins seven days prior to the ending date of a quarterly assessment period. The assessment reference date (A2300) on the MDS must be within the assessment reference period.

    c. An assessment must be submitted upon initiation of rehabilitation therapy if initiation of rehabilitation therapy occurs outside of the quarterly assessment reference period established in subdivision b.

d. An assessment must be submitted upon discontinuation of rehabilitation therapy if discontinuation of rehabilitation therapy occurs outside of the quarterly assessment reference period established in subdivision b.

4. The resident classification is based on resident characteristics and health status recorded on the resident assessment instrument, including the ability to perform activities of daily living, diagnoses, and treatment received. The classification is determined using an index maximizing method. Index maximizing identifies all groups for which a resident qualifies and the resident is then classified in group with the highest case-mix index. The resident is first classified in one or more of seven major categories. The resident is then classified into subdivisions of each major category based on the resident's activities of daily living score and whether nursing rehabilitation services are needed or the resident has signs of depression. A resident meeting the criteria for more than one classification shall be classified in the group with the highest case-mix weight.

5. For the purposes of this section:

   a. A resident's activities of daily living score used in determining the resident's classification is based on the amount of assistance, as described in the resident assessment instrument, the resident needs to complete the activities of bed mobility, transferring, toileting, and eating;

   b. A resident has a need for nursing rehabilitation services if the resident receives two or more of the following for at least fifteen minutes per day for at least six of the seven days preceding the assessment:

      i. Passive or active range of motion;

      ii. Amputation or prosthesis care;

      iii. Splint or brace assistance;

      iv. Dressing or grooming training;

      v. Eating or swallowing training;

      vi. Bed mobility or walking training;

      vii. Transfer training;

      viii. Communication training; or

      ix. Urinary toileting, bladder or bowel training program; and

   c. A resident has signs of depression if the resident's total severity score for depression is at least ten based on the following:

      i. Little interest or pleasure in doing things;

      ii. Feeling down, depressed, or hopeless;

      iii. Trouble falling asleep or staying asleep or sleeping too much;

      iv. Feeling tired or having little energy;

      v. Poor appetite or overeating;

vi. Feeling bad or failure or let self or others down;

vii. Trouble concentrating on things;

viii. Moving or speaking slowly or being fidgety or restless;

ix. Thoughts of being better off dead or hurting self; or

x. Short-tempered or easily annoyed.

6. The major categories in hierarchial order are:

a. Rehabilitation category. To qualify for the rehabilitation category, a resident must receive rehabilitation therapy. A resident who qualifies for the rehabilitation category is assigned a subcategory based on the resident's activities of daily living score. The rehabilitation category may be assigned within a classification period based on initiation or discontinuation dates if therapies are begun or discontinued on any date not within an assessment reference period.

b. Extensive services category. To qualify for the extensive services category, a resident must have an activities of daily living score of at least two and within the fourteen days preceding the assessment, received tracheostomy care or required a ventilator, respirator, or infection isolation while a resident.

c. Special care high category.

i. To qualify for the special care high category, a resident must have at least one of the following conditions or treatments and an activities of daily living score of at least two:

1. Comatose and completely dependent for activities of daily living;

2. Septicemia;

3. Diabetes with:
   a. Insulin injections seven days a week; and
   b. Insulin order changes on two or more days;

4. Quadriplegia with an activities of daily living score of at least five;

5. Chronic obstructive pulmonary disease and shortness of breath when lying flat;

6. A fever in combination with:
    a. Pneumonia;
    b. Vomiting
    c. Weight loss; or
    d. Tube feedings that comprise at least:
        i. Twenty-six percent of daily caloric requirements and at least five hundred and one milliliters of fluid through the tube per day; or
        ii. Fifty-one percent of daily caloric requirements;
    e. Parenteral or intravenous feedings provided in and administered in and by the nursing facility; or
    f. Respiratory therapy seven days a week.

ii. A resident who qualifies for the special care high category is assigned a subcategory based on the resident's activities of daily living score and whether the resident has signs of depression.

d. Special care low category.

i. To qualify for the special care low category, a resident must have at least one of the following conditions or treatments with an activities of daily living score of at least two:

1. Multiple sclerosis, cerebral palsy, or Parkinson's disease with an activities of daily living score of at least five;

2. Respiratory failure and oxygen therapy while a resident administered continuously for at least two hours or intermittently with at least two applications of at least thirty minutes each within the facility in the fourteen days preceding the assessment;

3. Tube feedings that comprise at least:
    a. Twenty-six percent of daily caloric requirements and at least five hundred and one milliliters of fluid through the tube per day; or
    b. Fifty-one percent of daily caloric requirements.

4. Two or more stage two pressure ulcers with two or more skin treatments;

5. Stage three or four pressure ulcer with two or more skin treatments;

6. Two or more venous or arterial ulcers with two or more skin treatments;

7. One stage two pressure ulcer and one venous or arterial ulcer with two or more skin treatments;

8. Foot infection, diabetic foot ulcer, or other open lesion of foot with application of dressings to the foot;

9. Radiation treatment while a resident; or

10. Dialysis treatment while a resident.

ii. A resident who qualifies for the special care low category is assigned a subcategory based on the resident's activities of daily living score and whether the resident has signs of depression.

e. Clinically complex category.

i. To qualify for the clinically complex category, a resident must have one or more of the conditions for the extensive services or special care categories with an activities of daily living score of zero or one or have at least one of the following conditions, treatments, or circumstances:

1. Pneumonia;

2. Hemiplegia or hemiparesis with an activities of daily living score of at least five;

3. Surgical wounds or open lesions with at least one skin treatment;

4. Burns;

5. Chemotherapy while a resident;

6. Oxygen therapy while a resident administered continuously for at least two hours or intermittently with at least two applications of at least thirty minutes each within the facility in the fourteen days preceding the assessment;

7. Intravenous medication provided, instilled, and administered by staff within the facility while a resident; or

8. Transfusions while a resident.

ii. A resident who qualifies for the clinically complex category is assigned a subcategory based on the resident's activities of daily living score and whether the resident has signs of depression.

f. Behavior symptoms and cognitive performance category to qualify for behavioral symptoms and cognitive performance category, a resident must have an activities of daily living score of less than six.

i. To qualify for the behavioral symptoms and cognitive performance category, a resident must either:

1. Be cognitively impaired based on one of the following:
   a. A brief interview of mental status score of less than ten;
   b. Coma and completely dependent for activities of daily living;
   c. Severely impaired cognitive skills; or
   d. Have a severe problem being understood or severe cognitive skills problem and two or more of the following:
      i. Problem being understood;
      ii. Short-term memory problem; or
      iii. Cognitive skills problem.

2. Exhibit behavioral symptoms with one or more of the following symptoms:
   a. Hallucinations;
   b. Delusions;
   c. Physical or verbal behavior symptoms directed towards others on at least four days in the seven days preceding the assessment;
   d. Other behavioral symptoms not directed toward others on at least four days in the seven days preceding the assessment.
   e. Rejection of care on at least four days in the seven days preceding the assessment; or
   f. Wandering on at least four days in the seven days preceding the assessment.

ii. A resident who qualifies for the behavioral symptoms and cognitive performance category is assigned a subcategory based on the resident's activities of daily living score and the resident's need for nursing rehabilitation services.

g. Reduced physical functioning category. To qualify for the reduced physical

functioning category, a resident may not qualify for any other category. A resident who qualifies for the reduced physical functioning category is assigned a subcategory based on the resident's activities of daily living score and the resident's need for nursing rehabilitation services.

7. Except as provided in subsection 2, each resident must be classified into a case-mix class with the corresponding group label, activities of daily living score, other criteria, and case-mix weight as follows:

Group	Classification Category	ADL Score	Nursing Rehabilitation	Signs of Depression	Relative Weight Grouper
RAE	Rehabilitation	15 – 16			1.65
RAD	Rehabilitation	11 – 14			1.58
RAC	Rehabilitation	6 – 10			1.36
RAB	Rehabilitation	2 – 5			1.10
RAA	Rehabilitation	0 – 1			.82
ES3	Extensive Services	2 – 16			3.00
ES2	Extensive Services	2 – 16			2.23
ES1	Extensive Services	2 – 16			2.22
HE2	Special Care High	15 – 16		Yes	1.88
HE1	Special Care High	15 – 16		No	1.47
HD2	Special Care High	11 – 14		Yes	1.69
HD1	Special Care High	11 – 14		No	1.33
HC2	Special Care High	6 – 10		Yes	1.57
HC1	Special Care High	6 – 10		No	1.23
HB2	Special Care High	2 – 5		Yes	1.55
HB1	Special Care High	2 – 5		No	1.22
LE2	Special Care Low	15 – 16		Yes	1.61
LE1	Special Care Low	15 – 16		No	1.26
LD2	Special Care Low	11 – 14		Yes	1.54
LD1	Special Care Low	11 – 14		No	1.21
LC2	Special Care Low	6 – 10		Yes	1.30
LC1	Special Care Low	6 – 10		No	1.02
LB2	Special Care Low	2 – 5		Yes	1.21
LB1	Special Care Low	2 – 5		No	.95

Group	Classification Category	ADL Score	Nursing Rehabilitation	Signs of Depression	Relative Weight Grouper
CE2	Clinically Complex	15 – 16		Yes	1.39
CE1	Clinically Complex	15 – 16		No	1.25
CD2	Clinically Complex	11 – 14		Yes	1.29
CD1	Clinically Complex	11 – 14		No	1.15
CC2	Clinically Complex	6 – 10		Yes	1.08
CC1	Clinically Complex	6 – 10		No	.96
CB2	Clinically Complex	2 – 5		Yes	.95
CB1	Clinically Complex	2 – 5		No	.85
CA2	Clinically Complex	0 – 1		Yes	.73
CA1	Clinically Complex	0 – 1		No	.65
BB2	Behavior/Cognition	2 – 5	Yes		.81
BB1	Behavior/Cognition	2 – 5	No		.75
BA2	Behavior/Cognition	0 – 1	Yes		.58
BA1	Behavior/Cognition	0 – 1	No		.53
PE2	Reduced Physical Functioning	15 – 16	Yes		1.25
PE1	Reduced Physical Functioning	15 – 16	No		1.17
PD2	Reduced Physical Functioning	11 – 14	Yes		1.15
PD1	Reduced Physical Functioning	11 – 14	No		1.06
PC2	Reduced Physical Functioning	6 – 10	Yes		.91
PC1	Reduced Physical Functioning	6 – 10	No		.85
PB2	Reduced Physical Functioning	2 – 5	Yes		.70
PB1	Reduced Physical Functioning	2 – 5	No		.65
PA2	Reduced Physical Functioning	0 – 1	Yes		.49
PA1	Reduced Physical Functioning	0 – 1	No		.45

8. Vacated.

9. A facility complying with any provisions of this section that requires a resident assessment must use the minimum data set in a resident assessment instrument that conforms to standards for a resident classification system described in 42 CFR 413.333.

Appendix A – VACATED

VACATED

VACATED

VACATED

INSTRUCTIONS FOR RATE CALCULATION

Allowable Historical Costs as Adjusted

Amounts are entered by cost categories and cost components from the provider cost report as of June 30 of the report year. Adjustments for unallowable costs, reallocations and reclassifications are made in accordance with the various sections of the state plan to arrive at allowable historical costs.

Census as reported for the report year is multiplied times the average case-mix weight for the provider to determine the standardized days.

Inflators

The adjustment factor identified in Section 24 is used to inflate allowable costs, except for property costs.

Cost Plus Inflators

Allowable historical costs as adjusted, except for property costs, are increased by the appropriate inflation factor to arrive at costs including inflation factors.

Applicable Units

Applicable Units are the number of resident days which are used in the calculation of the various components of the rate. Actual census days are the days reported on the cost report, adjusted to reconcile to departmental census records. Actual census days are used to calculate the Other Direct Care rate and the Other Direct Care Operating Margin. In addition, actual census days are used to calculate the Indirect rate, Property rate and Incentive unless the facility's occupancy percentage is below 90% of the licensed available beds is calculated. The 90% occupancy census is then used to calculate the Indirect rate, Property rate and Incentive. Standardized resident days are used to calculate the Direct rate and the Direct Care Operating Margin. Standardized resident days are actual census days weighted by the facility's average case-mix weight.

Rate Computation

Costs including appropriate inflation factors or any one-time adjustments for each cost category are divided by the greater of actual or 90% of licensed census days for Property and Indirect Care, by actual census days for Other Direct Care and by standardized resident days for Direct Care. The computed rate is then compared to the limit rate and the lesser of the two rates is the allowed rate. The limit rate is established using the methodology set forth in Section 25. If the provider's Indirect Care rate does not exceed the limit rate, an incentive up to a maximum of $2.60 is added. An operating margin of 3% based on the lesser of the actual rate excluding inflation or the limit rate excluding inflation is calculated.

Computation of Incentive

The Incentive rate calculation starts with Total Indirect allowable historical costs before inflation. Costs are divided by census days to determine an uninflated rate. This rate is compared to a limit rate determined using the methodology set forth in Section 25.4. The Incentive is determined using actual costs, not inflated costs. The difference between the actual uninflated rate and the limit rate is multiplied by 70% and is then compared to the maximum incentive allowable of $2.60.

Computation of Operating Margin

The Operating Margin rate calculation begins by dividing the reported adjusted costs for Direct and Other Direct Care costs by standardized resident days for Direct Care costs and by actual census days for Other Direct Care costs. This computed rate is then compared to a limit rate determined using the methodology set forth in Section 25.5. The lower of the computed rate or the limit rate is multiplied by 3% to establish the Operating Margin rate for Direct and Other Direct Care. The Operating Margin rate for Direct Care is then multiplied by the case-mix weight average to determine the allowed operating margin for Direct Care.

Daily Rates

The total Allowed Rate calculated is the rate for the rate weight of one. To calculate the rate for each of the 48 classifications, the rate is determined by multiplying the Allowed Rate for Direct for the rate weight of one by the case-mix weights set forth in Section 32. The Direct rate as calculated for each classification is then added to the rates for Property, Other Direct, Indirect, Incentive, and Operating Margin all of which remain the same for all classifications.